

## Intent:

This report contains high-level information on the Prescription Drug Monitoring Program (PDMP) and is intended to provide a summary of registration and reporting data specific to your profession.



## Overview:

The PDMP began in 2008 and is housed with the Board of Pharmacy under the Department of Commerce, Community, and Economic Development (DCCED) – Corporations, Business, and Professional Licensing (CBPL) section. Mandatory registration, reviewing, and reporting requirements went into effect in July 2017. All actively licensed practitioners with a valid DEA registration are required to register with the database; however, there are both practice-specific and supply-duration exemptions in AS 17.30.200(k) and (u) in which practitioners are not required to consult the PDMP. Generally, practitioners are required to review patient prescription history before prescribing, administering, and/or directly dispensing a federally scheduled II – IV controlled substance. If directly dispensing, practitioners must report this information to the PDMP on a daily basis. Information on exemptions can be found [www.pdmp.alaska.gov](http://www.pdmp.alaska.gov) under the Registration and Use Exemptions tab and includes information for federally-employed practitioners and pharmacists as well as information on situational exemptions to PDMP use. If mandatory registration and use exemptions do not apply and a licensee fails to register with the PDMP, disciplinary action may be taken by the State Medical Board.

Delegate access is allowed so long as the delegate holds an active license, certification, or registration under AS 08. Delegate access can help relieve time-constraints as reviewing and reporting tasks can be distributed to qualified staff.

With regards to prescriptive guidelines, CBPL's Joint Committee on Prescriptive Guidelines met in 2016 and came up with several recommendations, namely to recommend Washington's prescriptive guidelines, with the exception of reducing from a 120 morphine milligram equivalent (MME) threshold to a 90 MME threshold for consultation with a pain specialist. A summary of the recommendations and a copy of Washington's *Interagency Guideline on Prescribing Opioids for Pain* can found on the PDMP website at [www.pdmp.alaska.gov](http://www.pdmp.alaska.gov) under the Prescribing Resources tab.

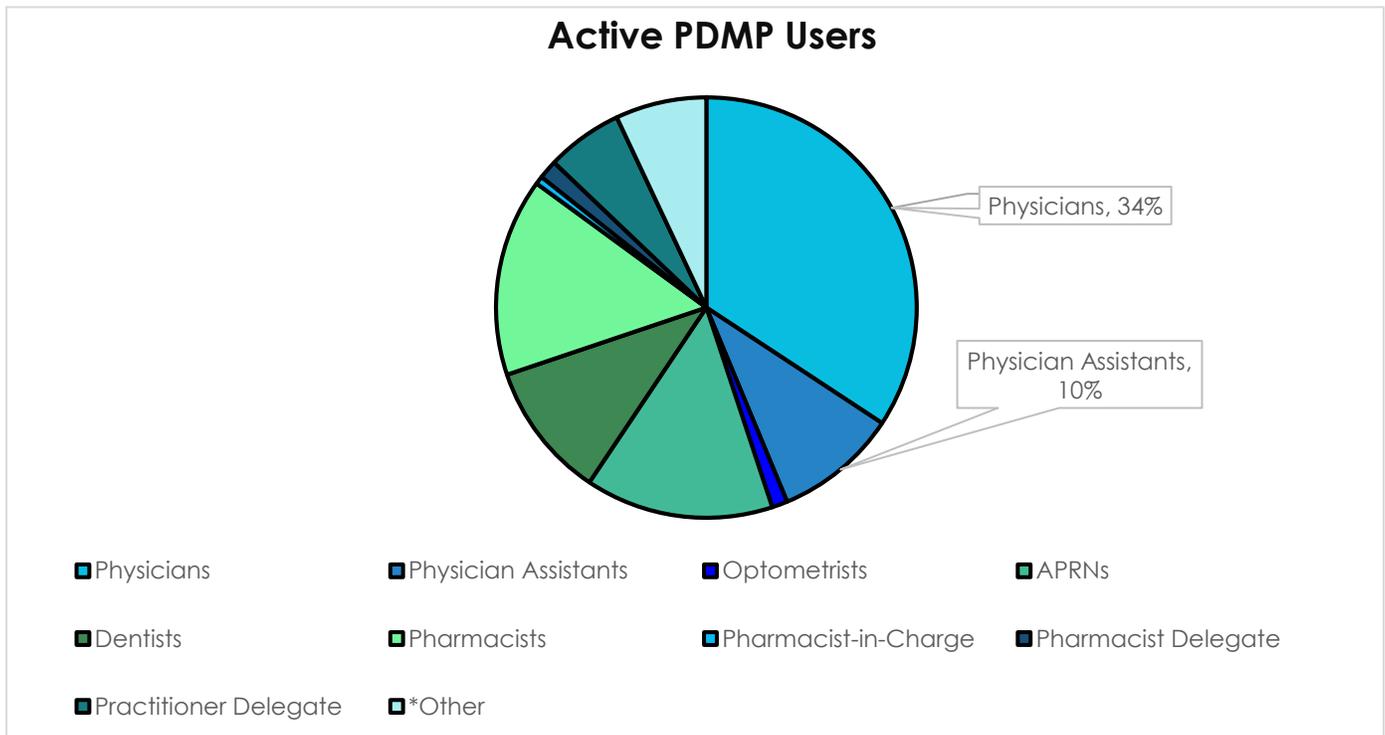
## Updates and Imminent changes:

- PDMP fees for initial and continued access went into effect on April 22, 2018 by authority of AS 17.30.200, which was subsequently implemented under 12 AAC 02.107. This requires a \$25.00 fee to be submitted before access to the controlled substance prescription database is granted.
- Effective July 1, 2018, applicants seeking licensure and who have a DEA registration must complete no less than two hours of education in pain management and opioid use and addiction within two years immediately preceding the date of application. Similarly, licensees with DEA registrations must complete at least two hours of continuing medical education (CME) for license renewal and to remain registered with the PDMP. Please visit the State Medical Board Website for additional information relating to CMEs:  
<https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/StateMedicalBoard.aspx>
- PDMP renewal for Physicians and Physician Assistants will be due by 12/31/18, however, licensees should begin renewing three months in advance to ensure timely processing.

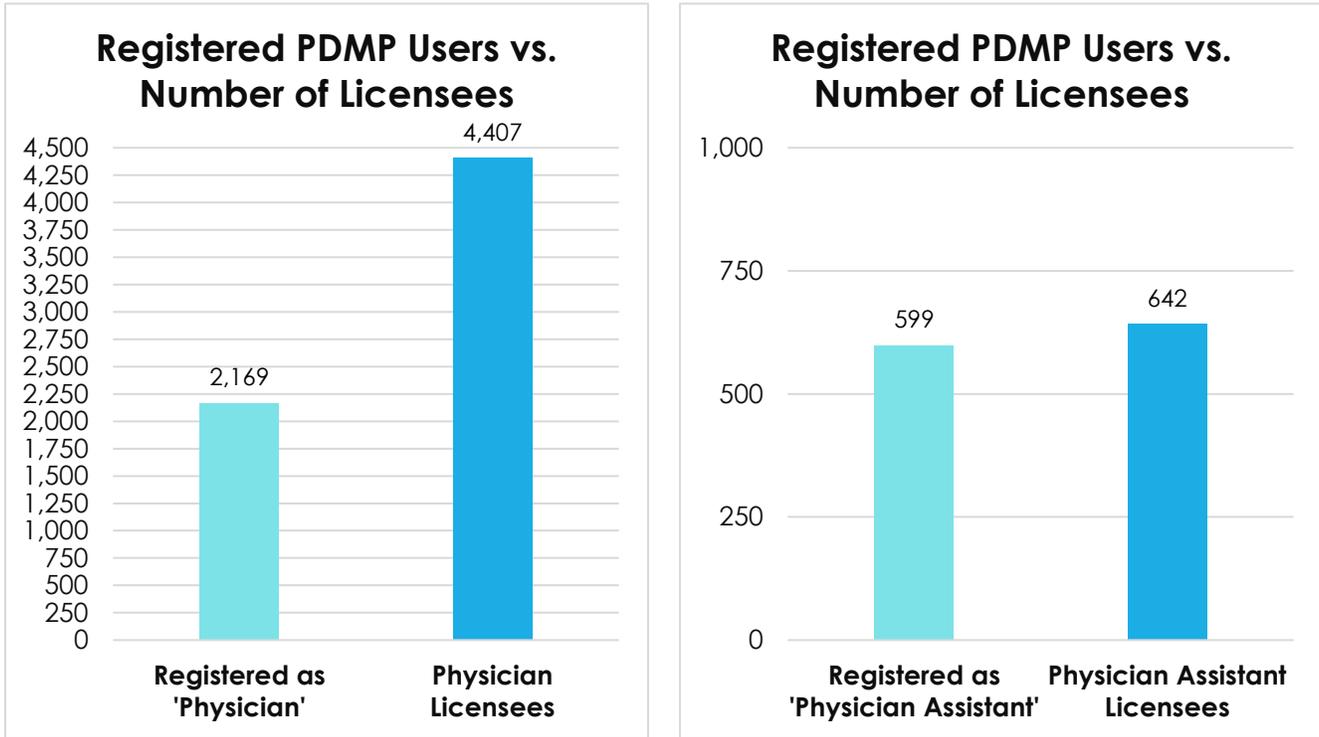
- Beginning June 2018, the PDMP began separating federal practitioners and pharmacists from those *required* to register by updating user roles, e.g.: ‘Physician’ to ‘IHS Prescriber’ (Indian Health Service) Prescriber.
- Beginning June 2018, all newly registered and renewed PDMP users are issued separate PDMP registration numbers and are searchable by name under the program ‘Prescription Drug Monitoring Program’ at: <https://www.commerce.alaska.gov/cbp/main/Search/Professional>

**Data:**

The Alaska State Medical Board regulates several license types, including physicians (MDs, DOs, and DPMs) and physician assistants. Presently, there are a total of 6,330 registered users, 2,169 of which are registered with the ‘Physician’ or ‘Podiatrist’ user role (collectively reported as Physicians) and 642 of which are registered as a ‘Physician Assistant’ (Figure 1). While physicians make up a relatively large percentage of registered users, the proportion of total licensed physicians registered with the PDMP is 49%. The number of physicians or physician assistants who do not hold an active DEA registration is not known. Physician assistants make up less than 10% of registered users and have reached 93% registration compliance (Figure 2).

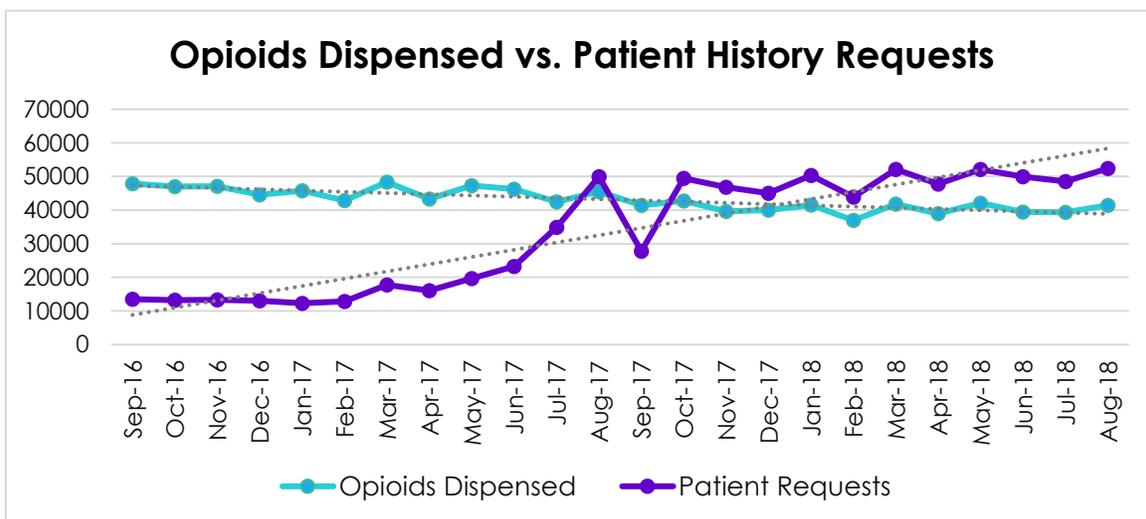


**Figure 1.** Physicians comprise 34% of actively registered users while physician assistants make up 10%. \*Other includes IHS and VA prescribers and dispensers, admin, medical residents, and out-of-state pharmacists. These federal practitioners and dispensers are not statutorily *required* to register by licensing statutes under AS 08 or the authorizing statute for the controlled substance prescription database, AS 17.30.200; however, they are permitted to have access and may be directed to do so by their federal employer.

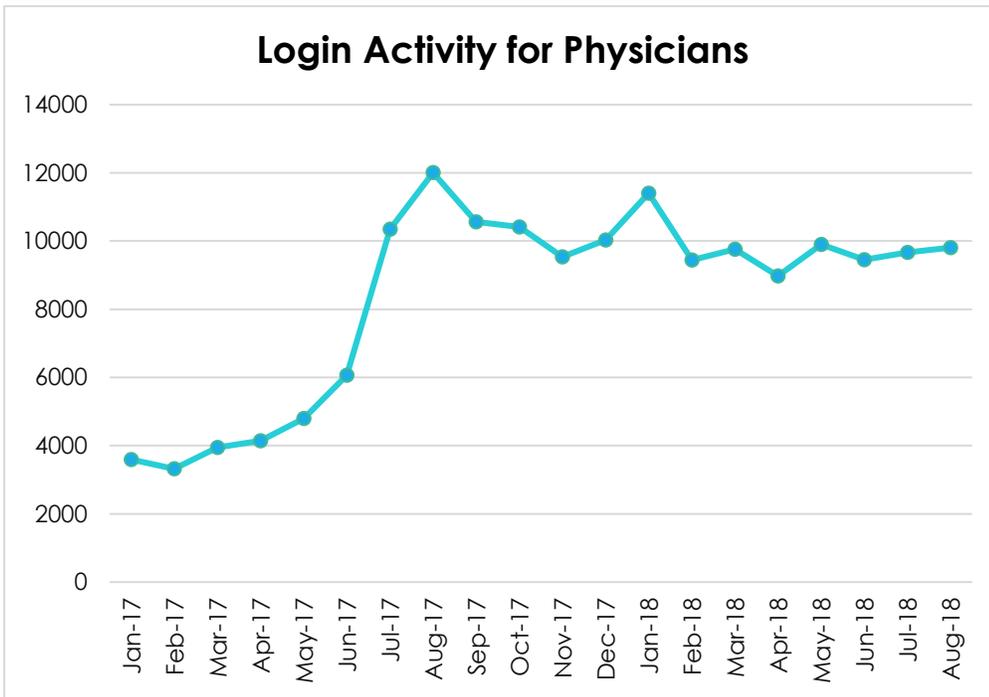


**Figure 2.** The proportion of licensed physicians and physician assistants to registered PDMP users of the corresponding user role. These figures for PDMP users exclude physicians and physician assistants working with the Indian Health Service, Veterans Administration, and Military who have corresponding user roles, e.g.: IHS Prescriber. The previous report from May included licensees working under federal employment as these user types were not tracked until June, 2018.

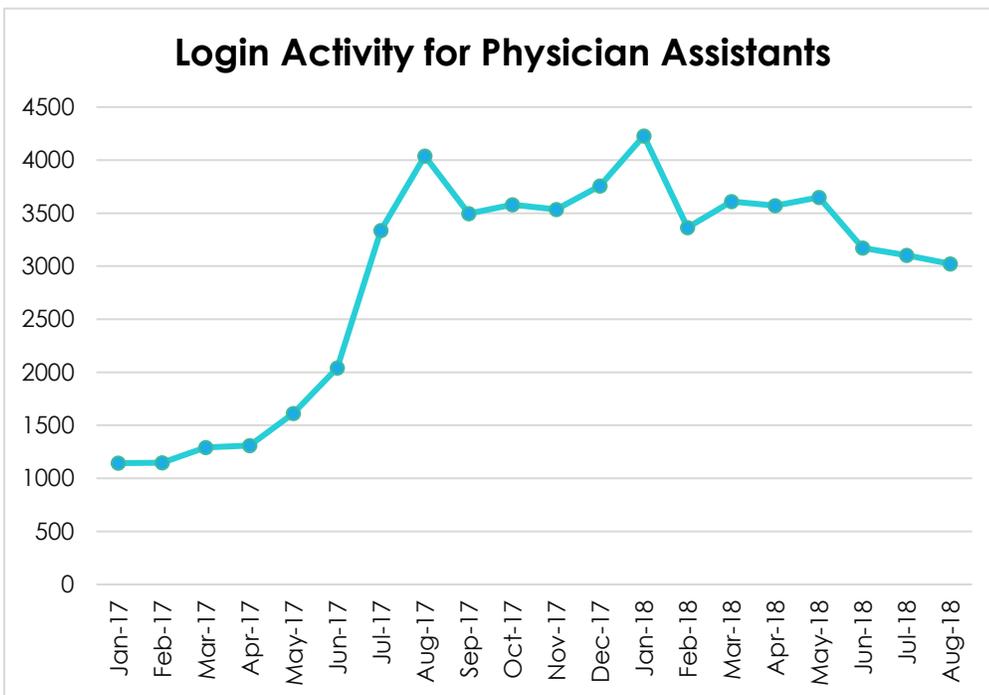
Figure 3 below shows the number of opioid prescriptions dispensed against the number of patient prescription history requests. Figures 4 – 7 shows the interaction activities of physicians and physician assistants captured from January 2017 to August 2018.



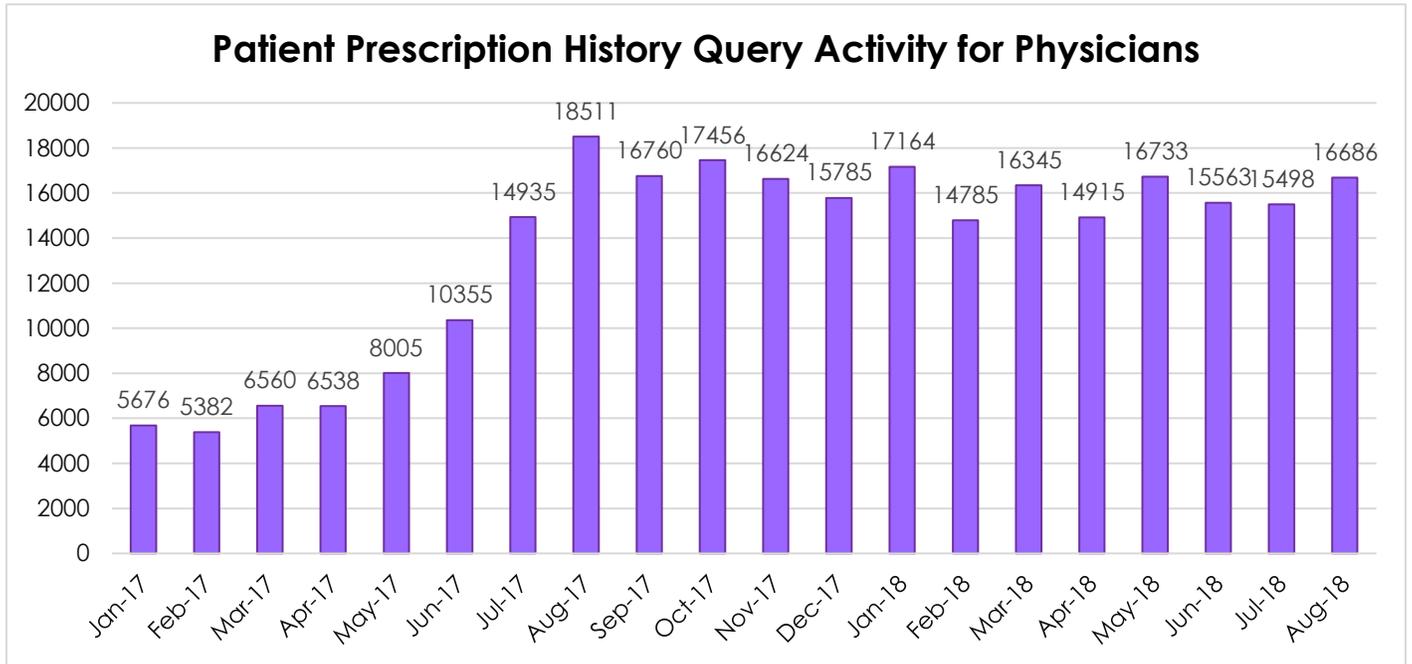
**Figure 3.** This graph shows the upward trend of patient prescription history requests in the PDMP, suggesting an inverse relationship between overall opioid dispensing in the state. The decrease in opioid dispensations may also be attributed to other factors, including prescriptive policies and salience of increased state-wide monitoring of prescribing practices as reflected in individual prescriber report cards.



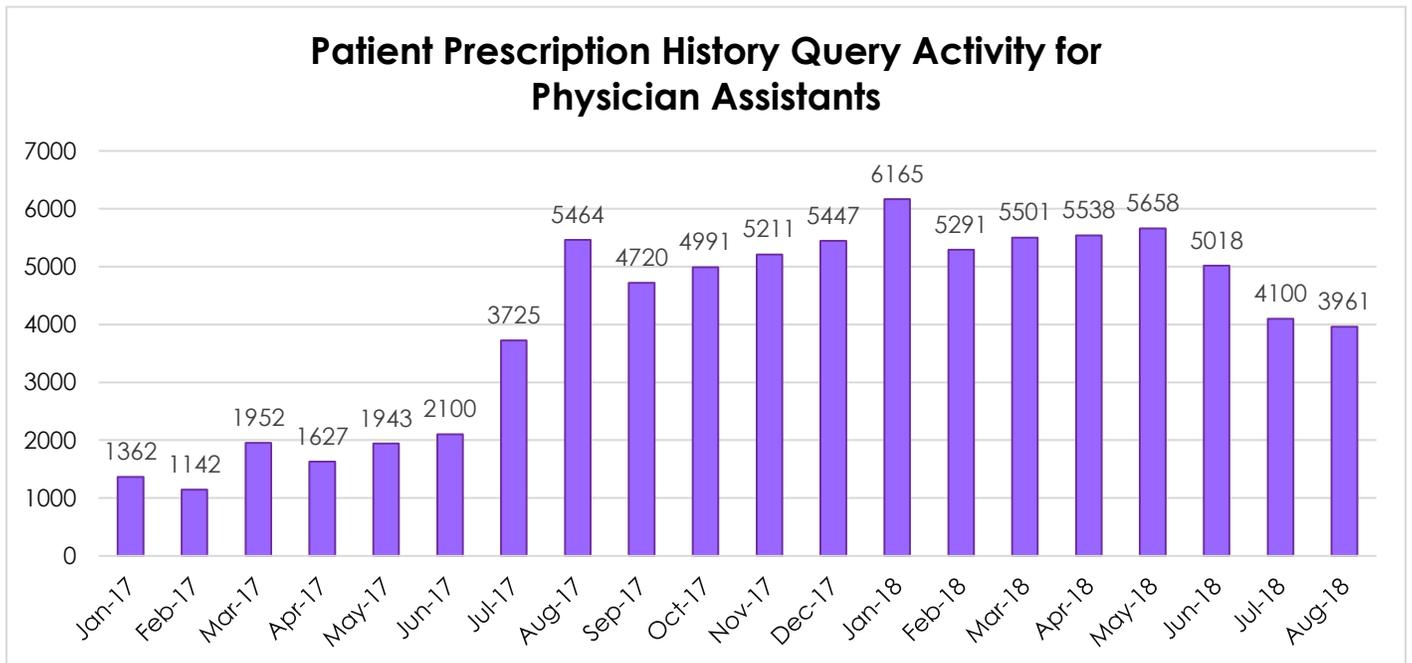
**Figure 4.** Login activity for Physicians has increased since January 2017, demonstrating increased compliance with PDMP utilization. The registration growth rate for physicians from January 2017 (668 registered users) to January 2018 (2,118 registered users) was 21.71%.



**Figure 5.** Login activity for Physician Assistants has also increased since January 2017. The registration growth rate for physician assistants from the beginning of 2017 to the beginning of 2018 was 17.3%.



**Figure 6.** Patient prescription history queries have increased substantially over the last year with a 202.4% increase from the beginning of the year in 2017 to the beginning of the year in 2018, owing to mandatory reporting and reviewing requirements effective July 2017. Rx queries peaked in August 2017 with 18,511 requests.



**Figure 7.** Patient history requests performed by physician assistants increased by 353% from January 2017 to January 2018, with requests peaking in the latter month at 6,165 requests.

Figures 7 – 12 describes trends in Morphine Milligram Equivalents (MMEs). Note that buprenorphine was removed from MME metrics effective in April 2018 due to changes in the CDC’s conversion factor calculations; however, the data below does include buprenorphine in the calculations through April as these figures reflect MMEs by month.

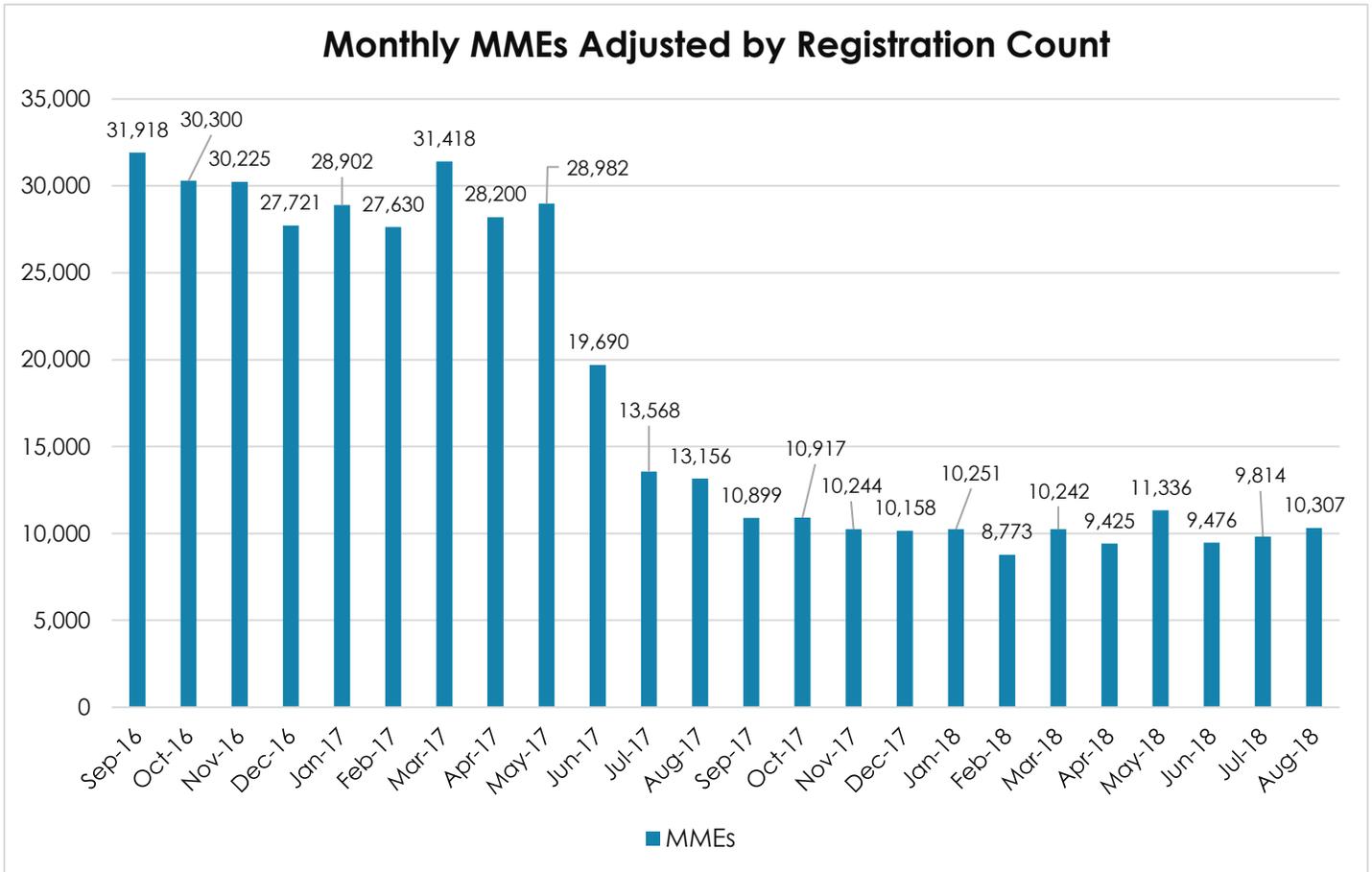


Figure 8. MMEs per month adjusted by the number of registered users.

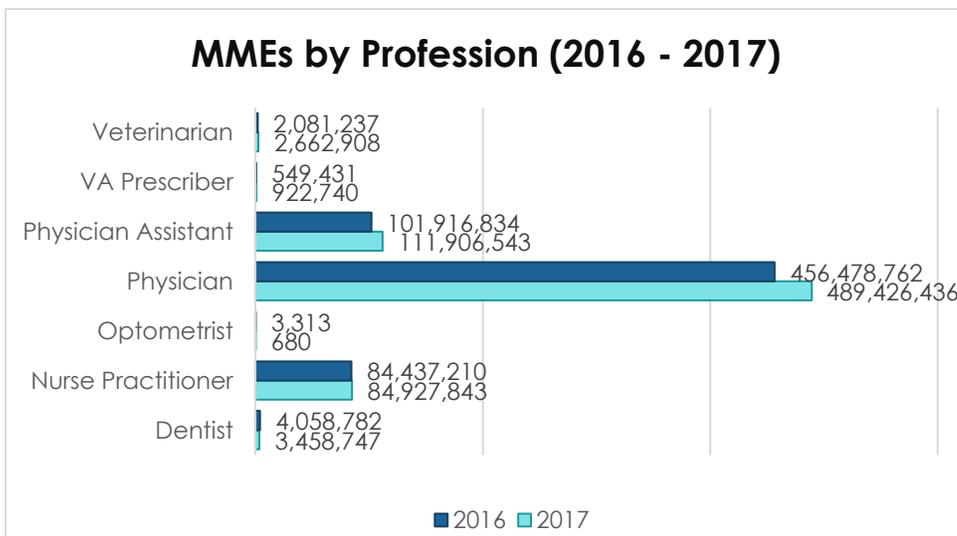
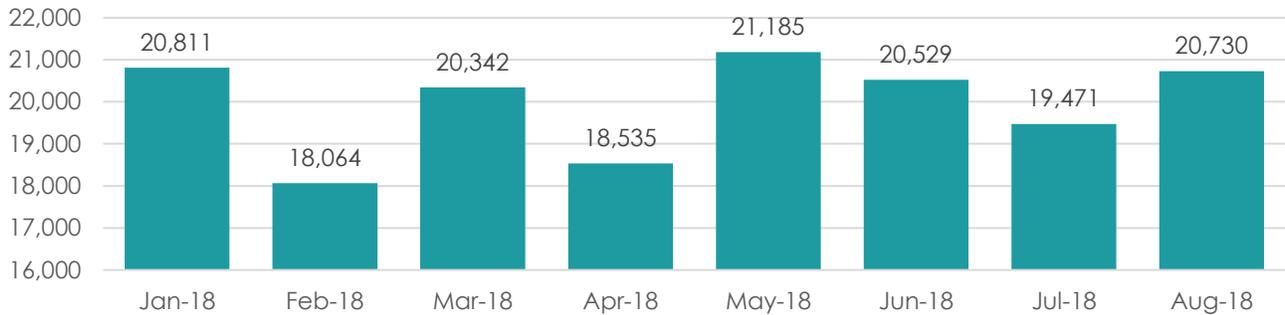


Figure 9. Of the total MMEs dispensed in 2016, 86% originated from prescriptions written by physicians and physician assistants. This represents a relative increase of 1.2% since 2017, when these practitioners prescribed 87% of total MMEs dispensed. While MMEs are higher in 2017 than in 2016, the number of opioid prescriptions has actually decreased. Please see figures 4 and 5 for figures that may help to explain this discrepant trend.

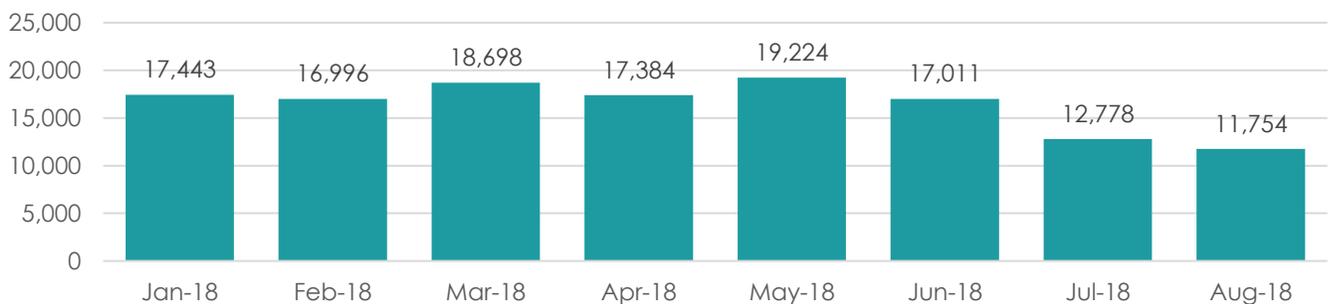
### Monthly MMEs by Profession: Physicians (2018)



Month-Year	MMEs	Registration Count
Jan-18	41,976,106	2017
Feb-18	36,742,636	2034
Mar-18	41,884,722	2059
Apr-18	38,701,702	2088
May-18	44,297,218	2091
Jun-18	43,335,774	2111
Jul-18	41,181,314	2115
Aug-18	43,967,393	2121

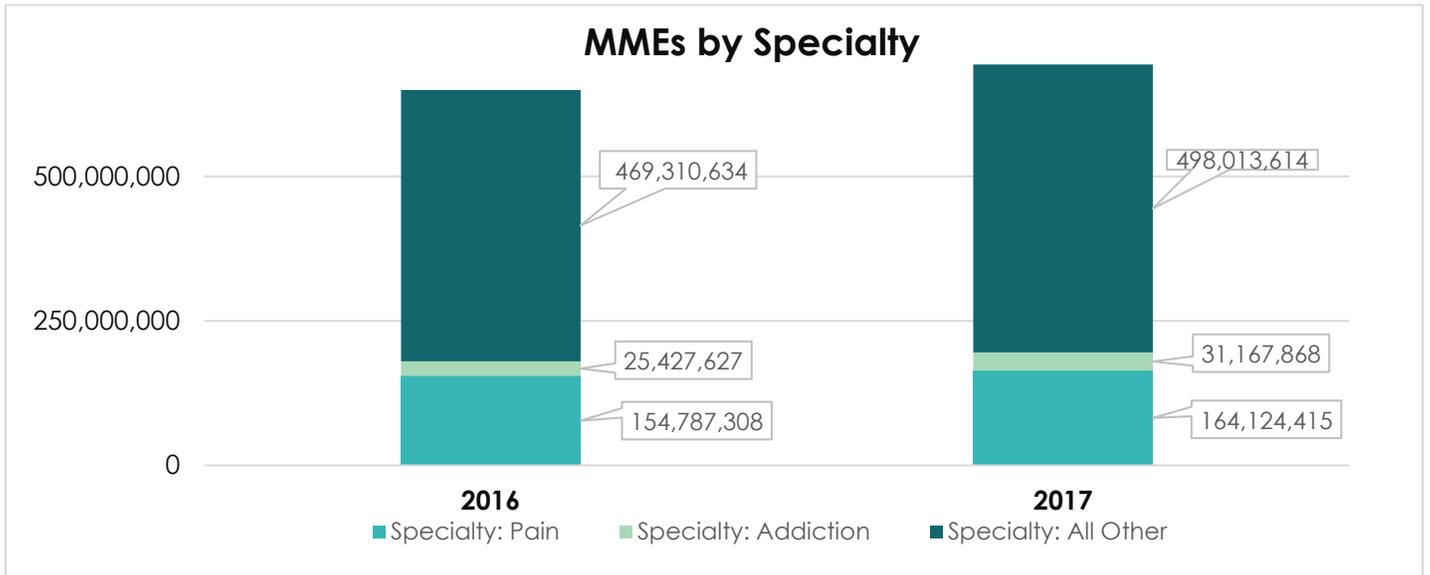
Figure 10. (Top): MMEs adjusted by physician registration count. (Left): Breakdown of MMEs by registration count per month in 2018.

### Monthly MMEs by Profession: Physician Assistants (2018)

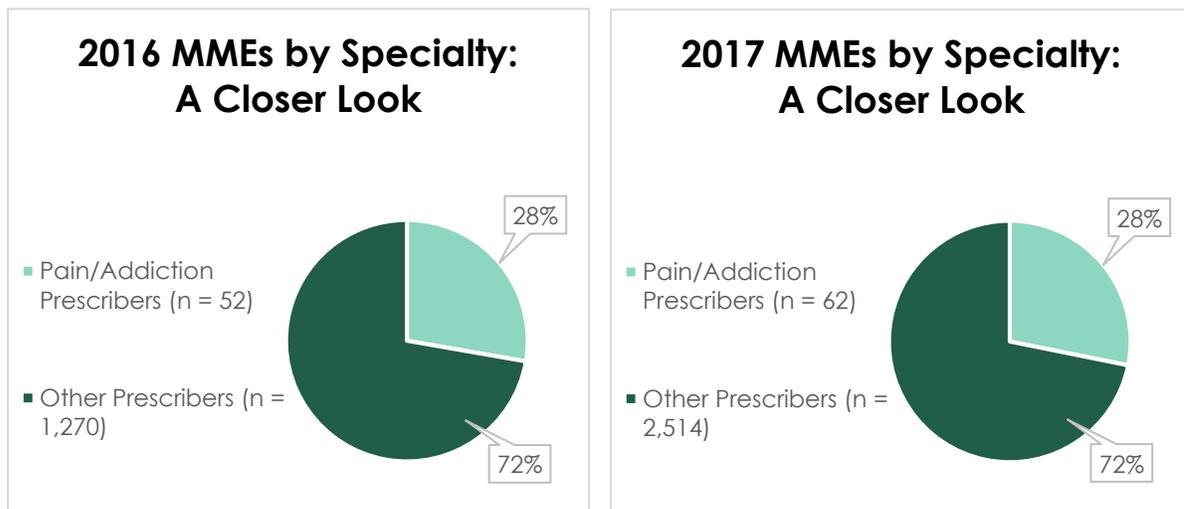


Month-Year	MMEs	Registration Count
Jan-18	10,082,017	578
Feb-18	9,857,571	580
Mar-18	10,919,642	584
Apr-18	10,221,514	588
May-18	11,322,794	589
Jun-18	10,138,505	596
Jul-18	7,628,265	597
Aug-18	7,040,908	599

Figure 11. (Top): MMEs adjusted by physician assistant registration count. (Left): Breakdown of MMEs by registration count per month in 2018.



**Figure 12.** Of the total MMEs prescribed by all prescriber profession types, information on MMEs by pain and addiction specialties are only available for APRNs, Physicians, and Physician Assistants. Pain and addiction specialties are among the top two specialties contributing significant to total MMEs. MMEs prescribed by practitioners with pain and addiction specialties accounted for 28% of total MMEs in both 2016 and 2017. Between 4 – 40+ specialties exist among prescriber professions, however, pain and addiction specialties contribute disproportionately higher MME relative to other specialties. During this period, the number of registered PDMP users increased by over 120% from 2016 to 2017.



**Figure 4.** While practitioners with pain and addiction specialties made up only .04% of registered PDMP prescribers in 2016 and .01% in 2017, these prescribers contributed disproportionately more MMEs than any other two combined specialty types. There was an overall increase in 10 prescribers who identified with these specialties from 2016 to 2017, which may have had a contributing factor to the increase in MMEs in 2017.